Guide to Determining Presumptive Eligibility for Pregnant Women

wisconsin Medicaid and BadgerCare

Information for Providers

Department of Health and Family Services

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State of Wisconsin
Department of Health and Family Services

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M E M O R A N D U M

DATE: November 22, 2002

TO: Presumptive Eligibility for Pregnant Women Providers, Managed Care Organizations

FROM: Peggy B. Handrich, Administrator
Division of Health Care Financing

SUBJECT: New Guide to Determining Presumptive Eligibility for Pregnant Women

The Division of Health Care Financing (DHCF) is pleased to provide you with a copy of the new Guide to Determining Presumptive Eligibility for Pregnant Women.

All policies included in the guide are effective for dates of service on and after March 1, 2003.

The Guide to Determining Presumptive Eligibility for Pregnant Women incorporates current Medicaid presumptive eligibility information into a single reference source. The guide replaces all prior presumptive eligibility for pregnant women publications.

This guide does *not* replace the All-Provider Handbook and all-provider *Wisconsin Medicaid and BadgerCare Updates*, the Wisconsin Administrative Code, or Wisconsin Statutes. Subsequent changes to presumptive eligibility for pregnant women policies will be published first in *Wisconsin Medicaid and BadgerCare Updates* and later in revisions to the Guide to Determining Presumptive Eligibility for Pregnant Women.

Additional Copies of Publications
All *Wisconsin Medicaid and BadgerCare Updates* and the Guide to Determining Presumptive Eligibility for Pregnant Women can be downloaded from the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/.*

We would like to thank everyone who reviewed the guide and provided comments.

Important Numbers

Wisconsin Medicaid's Eligibility Verification System (EVS) is available through the following resources to verify checkwrite information, claim status, prior authorization status, provider certification, and/or recipient eligibility:

Service	Information Available	Telephone Number	Hours
Automated Voice Response (AVR) System (Computerized voice response to provider inquiries.)	Checkwrite Information Claim Status Prior Authorization Status Recipient Eligibility*	(800) 947-3544 (608) 221-4247 (Madison area)	24 hours a day/ 7 days a week
Personal Computer Software and Magnetic Stripe Card Readers	Recipient Eligibility*	Refer to Provider Resources section of the All-Provider Handbook for a list of commercial eligibility verification vendors.	24 hours a day/ 7 days a week
Provider Services (Correspondents assist with questions.)	Checkwrite Information Claim Status Prior Authorization Status Provider Certification Recipient Eligibility*	(800) 947-9627 (608) 221-9883	Policy/Billing and Eligibility: 8:30 a.m. - 4:30 p.m. (M, W-F) 9:30 a.m. - 4:30 p.m. (T) Pharmacy: 8:30 a.m. - 6:00 p.m. (M, W-F) 9:30 a.m. - 6:00 p.m. (T)
Direct Information Access Line with Updates for Providers (Dial-Up) (Software communications package and modem.)	Checkwrite Information Claim Status Prior Authorization Status Recipient Eligibility*	Call (608) 221-4746 for more information.	7:00 a.m. - 6:00 p.m. (M-F)
Recipient Services (Recipients or persons calling on behalf of recipients only.)	Recipient Eligibility Medicaid-Certified Providers General Medicaid Information	(800) 362-3002 (608) 221-5720	7:00 a.m. - 5:00 p.m. (M-F)

*Please use the information exactly as it appears on the recipient's identification (ID) card or the EVS to complete the patient information section on claims and other documentation.

Recipient eligibility information available through the EVS includes:

- Dates of eligibility.
- Medicaid managed care program name and telephone number.
- Privately purchased managed care or other commercial health insurance coverage.
- Medicare coverage.
- Lock-In Program status.
- Limited benefit information.

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Preface

The Wisconsin Medicaid Guide to Determining Presumptive Eligibility for Pregnant Women is issued to presumptive eligibility providers who are Wisconsin Medicaid certified. It contains information that applies to fee-for-service Medicaid providers.

Wisconsin Medicaid is administered by the Department of Health and Family Services (DHFS). Within the DHFS, the Division of Health Care Financing (DHCF) is directly responsible for managing Wisconsin Medicaid.

Verifying Eligibility

Wisconsin Medicaid providers should always verify a client's eligibility before completing a Presumptive Eligibility for Pregnant Women Application to determine whether the client is already a Medicaid recipient. Wisconsin Medicaid's Eligibility Verification System (EVS) provides eligibility information that providers can access a number of ways.

Refer to the Important Telephone Numbers page at the beginning of this section for detailed information on the methods of verifying eligibility.

Legal Framework of Wisconsin Medicaid

The following laws and regulations provide the legal framework for Wisconsin Medicaid.

Federal Law and Regulation

- Law: United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI.
- Regulation: Title 42 CFR Parts 430-498 — Public Health.

Wisconsin Law and Regulation

- Law: Wisconsin Statutes: Sections 49.43-49.499 and 49.665.
- Regulation: Wisconsin Administrative Code, Chapters HFS 101-108.

Handbooks and *Wisconsin Medicaid and BadgerCare Updates* further interpret and implement these laws and regulations.

Handbooks and *Updates*, maximum allowable fee schedules, helpful telephone numbers and addresses, and much more information about Wisconsin Medicaid are available at the Wisconsin Medicaid Web site at *www.dhfs.state.wi.us/medicaid/*.

Medicaid Fiscal Agent

The DHFS contracts with a fiscal agent, which is currently EDS.

General Information

What is Presumptive Eligibility for Pregnant Women?

Presumptive eligibility for pregnant women is a Medicaid eligibility category that allows an uninsured or underinsured (i.e., insured without prenatal coverage) pregnant woman to receive immediate pregnancy-related outpatient services while her application for Wisconsin Medicaid is being processed.

Who Can Determine Presumptive Eligibility for Pregnant Women?

Providers must be currently certified as a Wisconsin Medicaid provider or have submitted an application for certification to Wisconsin Medicaid.

Providers may become qualified to make presumptive eligibility determinations if they meet state and federal requirements for Medicaid presumptive eligibility for pregnant women certification.

Federal Criteria

To meet federal requirements, providers are required to:

1. Provide services typically provided by one of the following:
   a. Clinics furnished by or under direction of a physician (s. 1905[a][9] of the Social Security Act).
   b. Outpatient hospitals (s. 1905[a][2][A] of the Social Security Act).
   c. Rural health clinics (s. 1905[a][2][B] of the Social Security Act).
2. **AND**, either participate in a program established under one of the following:
   a. A state perinatal program defined as a physician, nurse practitioner, certified nurse midwife, family planning clinic, outpatient hospital, or other clinic that provides prenatal medical care to Wisconsin Medicaid recipients.
   b. The Indian Health Services, or a health program or facility operated by a tribe or tribal organization (the Indian Self-Determination Act — Public Law 93-638).
   c. The Women, Infants, and Children Supplemental Food Program (s.4(a) of the Agriculture and Consumer Protection Act of 1973).

OR receive funds under one of the following:

   a. The Community Health Centers or Migrant Health Centers (s. 329 or 330 of the Public Health Act).
   b. The Maternal and Child Health Services Block Grant Programs (Title V of the Social Security Act).
   c. Title V of the Indian Health Care Improvement Act.

State Criteria

Providers must be currently certified as a Wisconsin Medicaid provider or have submitted an application for certification to Wisconsin Medicaid. Providers may submit their Presumptive Eligibility for Pregnant Women certification application with their Medicaid certification application.

Who is Eligible for Presumptive Eligibility for Pregnant Women?

Determining Eligibility

To be presumptively eligible, a woman must meet the following criteria:

- Her pregnancy must be medically verified (by a pregnancy test). Refer to

Appendix 1 of this guide for pregnancy verification criteria.

- Her family's gross income cannot exceed 185% of the federal poverty level (FPL) guidelines. Refer to Wisconsin Medicaid's Web site at *www.dhfs.state.wi.us/medicaid/* for the most up-to-date FPL guidelines.

Medicaid presumptive eligibility for pregnant women determinations are made based on pregnancy and income eligibility only. There is no asset test for presumptive eligibility.

Presumptive eligibility can begin on the day on which a qualified provider (i.e., the certifying agency) determines that the woman meets the criteria listed previously. This is determined by completing a Wisconsin Medicaid Presumptive Eligibility Application. Refer to Appendices 1 and 2 of this guide for the application completion instructions and a sample copy of the form, which may *not* be used for photocopying.

Where to Send Complete Applications

Upon completion, the certifying agency (the qualified provider) should submit the application to Wisconsin Medicaid within five days by either faxing or mailing the application. Fax applications to (608) 221-8815 or mail to:

Wisconsin Medicaid
Eligibility
6406 Bridge Rd
Madison WI 53784

When Wisconsin Medicaid receives the application from the certifying agency, a woman who meets the presumptive eligibility requirements is established on Medicaid's Eligibility Verification System (EVS) within one business day of the application's receipt.

Presumptive Eligibility Identification Cards

Included with the Presumptive Eligibility for Pregnant Women Application is a *beige* paper identification card that is given to the woman to use on a temporary basis until she receives a Wisconsin Medicaid identification card, which is a blue plastic *Forward* card. A woman can be eligible for presumptive eligibility from the date the qualified provider determines a woman is eligible through the end of the following month. The provider making the presumptive eligibility determination is required to indicate the dates of eligibility on the beige paper identification card. This paper card identifies a woman as presumptively eligible, and providers should accept it as proof of eligibility for the dates indicated on the card. Once presumptive eligibility is established on the EVS, a *Forward* card is sent to the woman.

Providers should remind clients that presumptive eligibility is temporary, despite their receiving a *Forward* card. Clients must also apply for Wisconsin Medicaid to receive the full range of Medicaid services, including inpatient delivery.

Refer to Appendices 1 and 2 of this guide for Wisconsin Medicaid Presumptive Eligibility for Pregnant Women Application instructions and a sample copy of the form, which may *not* be used for photocopying.

How Long Does Presumptive Eligibility Last?

Presumptive eligibility for pregnant women is *temporary* eligibility for pregnancy-related outpatient services only, so a pregnant woman should be advised to apply for Wisconsin Medicaid while she is eligible for presumptive eligibility services.

The period of presumptive eligibility coverage ends on the earliest of *either*:

- The day on which a client's Medicaid eligibility is established by the county/tribal social or human services department, W-2 agency, or Medicaid outstation site.
- The end of the month following the month in which a client is determined presumptively eligible by the qualified provider if the client does not apply for Wisconsin Medicaid or is determined ineligible for Wisconsin Medicaid.

When Wisconsin Medicaid receives the application from the certifying agency, a woman who meets the presumptive eligibility requirements is established on Medicaid's Eligibility Verification System (EVS) within one business day of the application's receipt.

Refer to Appendices 1 and 2 of this guide for sample Wisconsin Medicaid Presumptive Eligibility for Pregnant Women Application instructions and a sample form.

Extensions

Providers should inform clients that their county/tribal social or human services department, W-2 agency, or Medicaid outstation site may extend presumptive eligibility if the client files an application for Wisconsin Medicaid on or before the last day of the presumptive eligibility period.

Under the presumptive eligibility for pregnant women benefit, pregnant women are eligible to receive all covered outpatient pregnancy-related services.

How to Obtain Forms

A certified Medicaid provider may obtain blank Presumptive Eligibility for Pregnant Women Applications by sending a request or writing to:

Forms/Publications Manager
Division of Health Care Financing
PO Box 309
Madison, WI 53701-0309
Fax: (608) 267-3381

When requesting forms, indicate the form name, form number, and the quantity required.

Applying for Wisconsin Medicaid

Presumptive eligibility providers may assist presumptively eligible women completing the Medicaid application at the same time presumptive eligibility determination takes place.

Refer to Appendices 3 through 6 of this guide for the following forms:

- Medicaid, BadgerCare, and Family Planning Waiver Registration Application.
- Wisconsin Family Medicaid, BadgerCare, and Family Planning Instructions for Application and Review.
- Wisconsin Medicaid/BadgerCare Family Application.
- Medicaid Authorization of Representative.

For an up-to-date list of county agencies and Medicaid outstation sites, refer to the recipient home page of the Wisconsin Medicaid Web site at *www.dhfs.state.wi.us/medicaid1/*. Select "Contacts," then "Wisconsin Medicaid Contacts," then the "Wisconsin Medicaid Certifying Agencies County/Tribal Social or Human Services Departments" link.

Covered Services

Under the presumptive eligibility for pregnant women benefit, pregnant women are eligible to receive all covered outpatient pregnancy-related services. All Medicaid-certified outpatient providers can provide these services to women covered under presumptive eligibility. (Inpatient services are not covered under presumptive eligibility.)

Covered presumptive eligibility services provided before regular Medicaid eligibility is determined are reimbursed on a fee-for-service basis.

Pregnant women with presumptive eligibility are not enrolled in Medicaid HMOs. If regular Medicaid eligibility is established, pregnant women may be enrolled in Medicaid HMOs.

Appendix

Appendix 1
Instructions for Completing the Presumptive Eligibility for Pregnant Women Application

Section I — Nonfinancial Eligibility

To complete Section I, the provider should follow these instructions:

1. Inform the client that she may be eligible for Wisconsin Medicaid.
2. Determine if the client is a candidate for Medicaid presumptive eligibility for pregnant women by having her complete Section I, including questions 1 and 2.
   - If the client answers "yes" to question 1, she is already receiving Medicaid benefits. Stop here.
   - If the client answers "no" to question 2, she has indicated that she is not a U.S. citizen. Inform the client that she does not qualify for presumptive eligiblility. She may still be eligible for Wisconsin Medicaid, but she must apply at her county/tribal social or human services department, W-2 agency, or Medicaid outstation site.

     Since the client answered "no" to question 2, go to Section IV. Check the appropriate box indicating why presumptive eligibility cannot be determined, sign and date the form, and have the client sign and date the form. Detach and discard the bottom portion of the application and give one copy of the Presumptive Eligibility for Pregnant Women Application to the client. A copy should be retained for the provider's files. Mail the third copy to:

     Wisconsin Medicaid
     Eligibility
     6406 Bridge Rd
     Madison WI 53784

   - If the client answers "no" to question 1 and "yes" to question 2, continue on to the financial eligibility determination in Section II.

Note: If the client does not have a Social Security number (SSN), providers are required to call Wisconsin Medicaid's Recipient Services at (800) 362-3002 or (608) 221-5720, to obtain a pseudo-number. Wisconsin Medicaid will return the application if an SSN or a pseudo-number is not recorded.

Section II — Financial Eligibility

For presumptive eligibility determinations, the financial test is based on anticipated income. For this calculation, use the actual income expected during the month. (For example, a woman applying any time in September will use expected income for September.) Use the expected hours of work and expected dependent care expenses to calculate the employment expense and dependent care deductions.

Line 1

To be presumptively eligible for Medicaid benefits, the client must meet the income limits for the appropriate family size. All family income may have to be considered. Income that must be counted includes the spouse's income if the client is married or the parent's income if the client is a never-married minor, under age 18, who lives with her parent(s).

Note: When determining who is in the family, the provider is required to include family members living with the client. For example:

- Minor pregnant woman — Include the pregnant woman, her parents if she is a never-married minor, her minor natural or adopted siblings (full or half) living in the household, her minor natural or adopted children, if any, living in the household, and the number of unborn fetuses.
- Adult pregnant woman without spouse — Include the pregnant woman, her minor natural or adopted children living in the household, and the number of unborn fetuses.
- Adult pregnant woman with spouse — Include the pregnant woman, her spouse if he is living in the household, her minor natural or adopted children living in the household, and the number of unborn fetuses.

Line 2

Add all *gross earned* income (amount of money earned before any deductions are made). Refer to Line 6 of this appendix for income exclusions.

Appendix 1 (Continued)

Earned income includes:

- Wages.
- Salaries.
- Tips.
- Commissions.
- All other payments resulting from labor or personal service.

Include *self-employment* income. Self-employment income is income earned directly from one's own business, rather than earned as an employee with a specified salary or wages from an employer. Deduct costs when calculating self-employment income. Use monthly average for this calculation. If the business is ongoing and no changes have taken place, use the previous year's tax statement and divide by the number of months of operation.

Convert gross earned income (amount of money earned before any deductions are made) to the monthly total and enter this amount on Line 2.

Line 3

For each employed household member, enter a $90 work-related expense per month.

Line 4

Calculate the allowable expense deduction for dependent care. Actual dependent care for a dependent child (child care) or for an incapacitated adult (adult day care), if necessary for employment, may be determined as follows:

a. Up to $175 per dependent child age two or older or incapacitated adult per month.
b. Up to $200 per dependent child under age two per month.

Enter this amount on Line 4.

Line 5

Compute the total *net earned income* and enter this amount.

Line 6

Add all *unearned income* and enter this amount. Unearned income includes, but is not limited to:

- Pensions, annuities, insurance benefits, Social Security benefits (use gross amounts), Veterans' benefits, military allotments, and Workers' Compensation.
- Payments received for the rental of rooms, apartments, dwelling units, buildings, or land (if not reported as self-employment income). Taxes and the expense of upkeep may be deducted.
- Child support payments (deduct $50 per month from total child support payments).

Unearned income does *not* include:

- Supplemental Security Income.
- Wages of full- or part-time students (unless the person is a part-time student who is employed full time).
- Student loans or grants, regardless of source, including work study.
- Reimbursement for expenses which the client has incurred or paid, except for reimbursement for normal household living expenses such as rent, clothing, or food eaten at home.
- Foster care or subsidized adoption payments.
- Life insurance policy dividends.
- Earned Income Tax Credits payments.
- Payments made by a third party directly to landlords or other vendors.
- Governmental (federal, state, or local) rent and housing subsidies, including payments made directly to the client/recipient for housing or utility costs (e.g., U.S. Department of Housing and Urban Development [HUD] utility allowances).

Do not include the following *nutrition-related benefits:*

- The Food Stamp Program allotment.
- Any United States Department of Agriculture (USDA)-donated food (surplus commodities) and other emergency food.
- Home produce that household members use for their own consumption.
- Supplemental food assistance received under the Child Nutrition Act of 1966, as amended.
- Benefits received under the National School Lunch Act, as amended.
- Benefits received under the Women, Infants, and Children (WIC) Supplemental Nutrition Program.

- Benefits received from the Emergency Food and Shelter National Board Program and the Federal Emergency Management Assistance Program (P.L. 98-8), such as food vouchers and/or cash.
- Benefits from USDA's Child Care Program.

Exclude the following income:

- If the pregnant woman or an individual whose income is included in determining her eligibility has been ordered by a court to pay child support to a person who is not a family member (e.g., the child is not living in the same home as the parent paying child support), disregard the amount of the support in determining the *total net income*.

Line 7
Add the *total net income* (Line 4) and *total net unearned for total net income* (Line 5) and enter this amount.

Line 8
Compare *total net income* to the *monthly standard* for the family size from the federal poverty level (FPL) guidelines. The client's income must be at or below 185% of the FPL. The FPL guidelines are updated annually and published in a *Wisconsin Medicaid and BadgerCare Update*. Refer to the Wisconsin Medicaid Web site at *www.dhfs.state.wi.us/medicaid/* for the most recent *Update* with up-to-date FPL guidelines.

Section III — Verification of Pregnancy

Complete pregnancy verification information. Providers may accept written verification of the pregnancy and due date from a physician, physician assistant, licensed nurse practitioner, registered nurse working in Maternal and Child Health, registered nurse working in a publicly funded family planning project, or a certified nurse midwife as verification of the pregnancy. Acceptance of this written verification means that providers do not have to perform an additional pregnancy verification.

Section IV — Notice

If the Client Is Presumptively Eligible

If the client meets the income eligibility limits and the provider has medically verified her pregnancy, she is presumptively eligible. The provider should check the appropriate boxes and sign the presumptive eligibility form.

If the Client Is Not Presumptively Eligible

If the client does not qualify under the income guidelines, providers are required to do the following:

- Check the appropriate box on the form indicating the reason for the client's ineligibility.
- Sign and date the form.
- Have the client sign and date the application indicating that she understands that, even though the provider has not found her presumptively eligible, she may still be eligible for Wisconsin Medicaid. Encourage the client to apply for Wisconsin Medicaid at her county/tribal social or human services department, W-2 agency, or Medicaid outstation site.
- Inform the client that she may be eligible for the WIC program and provide her with a copy of the WIC pamphlet from the Division of Public Health. For further information, refer to the Division of Public Health's WIC Web site at *www.dhfs.state.wi.us/WIC/*.
- Detach and discard the bottom portion of the application and provide the client with a copy of the presumptive eligibility form. This will serve as the client's notice of denial of eligibility. Retain a copy for your files and mail a copy to Wisconsin Medicaid at:

  Wisconsin Medicaid
  Eligibility
  6406 Bridge Rd
  Madison WI 53784

Section V — Temporary Identification Card

Complete the following items on the temporary (beige) card if the client is presumptively eligible:

1. *Card validity dates.*

   Medicaid presumptive eligibility for pregnant women begins on the day eligibility is determined and continues through the last day of the month following the month in which presumptive eligibility is determined (e.g., a woman whose presumptive eligibility begins June 6 is eligible through the end of July).

2. *Medical status code.*

   Check either the medical status code "PE" or "P2" box, depending on income determined from Tables I and II of the FPL. The FPL guidelines are updated annually and published in an *Update*. Refer to the Wisconsin Medicaid Web site at

www.dhfs.state.wi.us/medicaid/ for the most recent FPL guidelines.

3. *Social Security number.*

   Enter the client's SSN or pseudo-number. Add a zero on the end.

4. *Agency code.*

   Agency code assigned to the provider.

5. *Client name and address.*

   Print or type the client's full name and address in the box provided at the bottom of the card.

Providers are then required to:

- Have the client sign the Presumptive Eligibility for Pregnant Women Application.
- Inform the client that her presumptive eligibility lasts from the month she is found eligible until the end of the following month. Before this time period is over, the client must apply for Wisconsin Medicaid either by mail, telephone, or in person. The client may fill out a Family Medicaid/BadgerCare Application and Review Form (HCF10100, formerly DES-12277) furnished by the provider or the provider may refer her to her local county/tribal social or human services department, W-2 agency, or Medicaid outstation site. If the client does not apply within this time period, presumptive eligibility will end. Refer to Appendices 3 through 6 for a Medicaid, BadgerCare, and Family Planning Waiver Registration Application; Wisconsin Family Medicaid, BadgerCare, and Family Planning Application and completion instructions; and a Medicaid Authorization of Representative form.
- Inform the client that her county/tribal social or human services department, W-2 agency, or Medicaid outstation site may extend eligibility if the client files an application on or before the last day of the presumptive eligibility period.
- Give the client a copy of the Presumptive Eligibility for Pregnant Women Application. Explain to the client that this will serve as verification of her pregnancy when applying for a Medicaid eligibility determination.
- Detach the bottom portion of the application for the client to use as a temporary Medicaid card (beige). This temporary Medicaid card entitles the client to outpatient pregnancy-related care provided by a Medicaid-certified provider.
- Inform the client that a plastic Wisconsin Medicaid *Forward* card will be mailed to her. The *Forward* card is valid only for the temporary presumptive eligibility period and is still limited to outpatient pregnancy-related care only. The client must apply for Medicaid eligibility through her county/tribal social or human services department, W-2 agency, or Medicaid outstation site to receive full Medicaid benefits, including any inpatient care.
- Inform the client that if she is determined to be eligible for Wisconsin Medicaid, she may continue to use the *Forward* card. The card will then be valid for all Medicaid-covered services, including inpatient care, until the end of the month in which the 60th postpartum day occurs.
- Inform the client that she may be eligible for the WIC program and provide her with a copy of the WIC pamphlet from the Division of Public Health. For further information, refer to the Division of Public Health's WIC Web site at *www.dhfs.state.wi.us/WIC/*.
- Mail or fax the Presumptive Eligibility for Pregnant Women Application to Wisconsin Medicaid at the following address or fax number:

  Wisconsin Medicaid
  Eligibility
  6406 Bridge Rd
  Madison WI 53784
  Fax: (608) 221-8815

  If the Presumptive Eligibility for Pregnant Women Application is faxed, a copy should also be mailed to the county/tribal social or human services department, W-2 agency, or Medicaid outstation site where the client has applied for Wisconsin Medicaid. Wisconsin Medicaid must receive determination on or before the fifth working day after the day determination is made. The notice requirement is met when Wisconsin Medicaid receives its copy of the completed application, either by fax or mail.
- Explain to the client that a presumptive eligibility determination does not guarantee that her county/tribal social or human services department, W-2 agency, or Medicaid outstation site will find her eligible for Wisconsin Medicaid because of other requirements that may apply.

Appendix 2
Sample Presumptive Eligibility for Pregnant Women Application

(A sample of the Presumptive Eligibility for Pregnant Women Application is located on the following page.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 10081 (Rev. 06/02)

STATE OF WISCONSIN
HFS 103.03(4), Wis. Admin. Code

WISCONSIN MEDICAID

PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN APPLICATION

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients. The provision of your Social Security number (SSN) is mandatory under the Wisconsin Statutes. Your SSN will be used for income verification and eligibility determination. If you do not provide your SSN, your application for benefits will be denied.

SECTION I — NONFINANCIAL ELIGIBILITY

Client Information	Preferred language (other than English) in which to receive information:	
Name — Client (Last, First, M.I.)	Birth Date (MM/DD/YY)	Telephone Number
Address (Street / P.O. Box, City, State, Zip Code)		County of Residence

1. Are you currently eligible for Wisconsin Medicaid? (If Yes, stop here.)	❑ YES	❑ NO
2. Are you a U.S. citizen? (If you answered "NO" to question 2, stop here. The provider cannot determine your presumptive eligibility.)	❑ YES	❑ NO

SECTION II — FINANCIAL ELIGIBILITY

1. How many family members, in the same household, live on this income? Include the number of medically verified fetuses.	
2. Enter the amount of money earned monthly before any deductions. Include spouse's income or, if client is a never-married minor living with her parent(s), include parent's(s') income. NOTE: Include any self-employment income minus costs (use monthly average).	$
3. Enter allowable work-related expense deduction for each employed household member.	$
4. Enter allowable amount of dependent care.	$
4a. Add lines 3 and 4.	$
5. Enter net-earned income (subtract line 4a from line 2).	$
6. Enter total unearned income (VA, SSA, contributions, unemployment compensation, etc.).	$
7. Enter total net income (add lines 5 and 6).	$
8. Compare the total net income (line 7) with the monthly standard for the appropriate family size from the income guidelines. Does the client meet the eligibility income limits?	❑ YES ❑ NO

SECTION III — VERIFICATION OF PREGNANCY

Positive pregnancy. Expected delivery date (MM/DD/YY)

SECTION IV — NOTICE

1. ❑ I certify that the above-named client has a medically verified pregnancy, and that, based on the preliminary information provided above, she qualifies for Wisconsin Medicaid presumptive eligibility for pregnant women. I have informed her of the requirement to apply by mail, telephone, or in person at her county/tribal social or human services department by the end of the month following the current month.

OR

❑ I have determined that the above-named client is not presumptively eligible for Wisconsin Medicaid for the following reason(s)

❑ She is currently eligible for Wisconsin Medicaid. ❑ She is not a U.S. citizen.
❑ She does not qualify under the income guidelines. ❑ Her pregnancy cannot be verified.

Name — Qualified Provider (Type or Print)	Address — Qualified Provider	
SIGNATURE — Qualified Provider	Wisconsin Medicaid Provider Number	Date Signed

2. ❑ I certify, under penalty of false swearing, that the information on this application and given in connection with it is a true and complete statement of facts according to my best knowledge and belief. I understand that in order to be determined eligible for Wisconsin Medicaid, I must apply by mail, telephone, or in person before the end of the month following the month in which I was determined eligible for presumptive eligibility and that my presumptive eligibility also ends on that date.

OR

❑ I understand that I do not meet the eligibility requirements for Wisconsin Medicaid presumptive eligibility. The qualified provider named above has informed me that I may still apply for Wisconsin Medicaid.

SIGNATURE — Client	Date Signed

SECTION V — TEMPORARY IDENTIFICATION CARD

This card identifies you as being eligible to receive outpatient pregnancy-related care through Wisconsin Medicaid. You may receive these services from any Medicaid provider. You must present this card *before* receiving care.

Card Validity Dates (MM/DD/YY)		Medical Status Code	Social Security Number	Agency Code
From	Through	❑ PE ❑ P2		

Client Name and Address

This card entitles this individual to receive outpatient pregnancy-related care through Wisconsin Medicaid from certified Medicaid providers during the time period listed. The individual listed has been determined presumptively eligible for Wisconsin Medicaid in accordance with s. 49.465, Wis. Stats.

WISCONSIN MEDICAID TEMPORARY PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN IDENTIFICATION CARD

Appendix 3
Medicaid, BadgerCare, and Family Planning Waiver Registration Application (for photocopying)

(A copy of the Medicaid, BadgerCare, and Family Planning Waiver Registration Application is located on the following pages.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 10129 (01/03) (Formerly DES 11605)

STATE OF WISCONSIN
WI Stats. s. 49.47

MEDICAID, BADERCARE AND FAMILY PLANNING WAIVER REGISTRATION APPLICATION

Completing this form will set your application date for Medicaid, BadgerCare and Family Planning Waiver. You only have to complete the bottom portion of this application in order to set your application date. However, the entire Medicaid, BadgerCare, and Family Planning Waiver application process must be completed before you can receive benefits. You will be notified within 30 days whether or not you are eligible.

It is important to set your application date as soon as you can because if you are eligible, you may receive benefits from your application date. Medicaid benefits for eligible persons may be backdated up to three months beginning prior to the application date. BadgerCare and Family Planning Waiver benefits **cannot** be backdated.

You can apply for Medicaid/BadgerCare by mail, telephone or in person. If you choose to apply by mail, you may get a Wisconsin Medicaid/BadgerCare Family application at your local county/tribal social or human services department. To schedule an appointment to apply in person or by telephone contact your county/tribal social or human services department.

If you need an interpreter or other help in completing this form, ask for help. You may have another adult act as an authorized representative and complete the application process. You are responsible for all information provided, even if an authorized representative completes the application process for you.

Learn about general Medicaid information, as well as your rights and responsibilities in the "*Wisconsin Medicaid Program – Eligibility and Benefits*" brochure. If you do not have one, ask for one at your local county/tribal agency. If you have questions about your rights and responsibilities, please ask about them.

- -

Instructions to Applicant: Use only blue or black ink. Do not complete shaded area.

Under Wisconsin Statute section 49.45(4), personally identifiable information is only used directly for the administration of the Medicaid program.

*Providing or applying for a Social Security Number (SSN) is voluntary; however any person who wants Wisconsin Medicaid but does not want to provide their SSN or apply for one will not be eligible for benefits, pursuant to Wisconsin Statutes section 49.82(2). Your SSN permits a computer check of your information with other government agencies, such as the federal Internal Revenue Service (IRS), federal Social Security Administration (SSA) and the Wisconsin Department of Workforce Development. In addition, the Medicaid program will match your name and SSN with information provided by health insurance carriers to determine if you have other health insurance.

RFA / Case Number	Social Security Number*	Birthdate (mm/dd/yy)	Gender (check one) ☐ Male ☐ Female
Applicant Name (Last, First, MI)		Telephone Number	
Address (Street, City, State, Zip Code)			
Signature – Applicant		Date Signed	

Keep the top portion of page for your records. Return the bottom portion of this form to: (County/tribal social or human service department must stamp or write in address of where to return form.)

Reset Form

Appendix 4
Wisconsin Family Medicaid, BadgerCare, and Family Planning Waiver Instructions for Application and Review (for photocopying)

(A copy of the Wisconsin Family Medicaid, BadgerCare, and Family Planning Waiver Instructions for Application and Review is located on the following pages.)

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DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing WI Statutes s. 49.47
HCF 10100A (Formerly DES 12277) (01/03)

WISCONSIN FAMILY MEDICAID, BADGERCARE, AND FAMILY PLANNING WAIVER INSTRUCTIONS FOR APPLICATION AND REVIEW

This application is to be used by families with children under age 19 and pregnant women who are applying for Wisconsin Medicaid or BadgerCare, and for single women between the ages of 15 and 44 who are applying for the Family Planning Waiver. This is not an application for food stamps, child care, or W-2. If you are interested in applying for these assistance programs you must contact your local county/tribal social or human services department, or your W-2 agency. These programs provide persons or families help with the costs of food, the costs of child care, or finding a job as part of W-2.

If you need help filling out this application or wish to answer the questions in person or over the telephone, contact your local county/tribal social or human services department. For other questions regarding Wisconsin Medicaid or BadgerCare, please call Medicaid Recipient Services at 1-800-362-3002. Information is also available on the Department of Health and Family Services Web site at: ***HTTP://WWW.DHFS.STATE.WI.US/MEDICAID/***.

If you have a disability and need to access the instructions and application in an alternate format, or need it translated to another language, please contact (608) 266-3356 or (608) 266-2555 TTY (toll free). All translation services and translated information are free of charge.

HOW TO USE THIS FORM

1. Read instructions completely, before completing application.

2. Print clearly. Use blue or black ink.

3. Fill out the application completely. Answer all the questions. There may be a delay in Medicaid, BadgerCare, or Family Planning Waiver benefits if the application is not complete. If your application is not complete or you requested retroactive eligibility your county/tribal social or human services department will contact you for more information.

4. Do not write in the shaded sections.

5. Enter information about all the people that live in your household. If you need more space add a second sheet.

6. If you are pregnant, please include with your application a signed and dated note from your doctor or another health care professional saying that you are pregnant and identifying your expected due date.

7. You may authorize a representative to apply for you. Complete and send the Authorized Representative form included in these instructions with your application. This form authorizes a representative to complete and sign the application for you. A legal guardian, conservator, or power of attorney/durable power of attorney may apply for an individual without separate authorization by the individual.

IMPORTANT INFORMATION

The following is important information regarding Wisconsin Medicaid/BadgerCare eligibility.

- Your application date is the date your application is received by your county/tribal social or human services department. The application must include at least your name, address, and signature. A decision regarding your eligibility for Medicaid, BadgerCare or Family Planning Waiver will be mailed to you within 30 days of the application date. Unsigned forms will not be processed and will be returned.

  It is important to apply as soon as possible. Eligibility for benefits is based on your application date. If you are eligible, you may be able to get Medicaid benefits for up to three months before your application date if all the needed information is collected for the prior months and you are determined to have been eligible in those

months. If you are interested in help paying for health care for any of the three months prior to your application date (backdating), make sure you checked the "Yes" box on the application where the backdating question is asked.

There is no backdating for BadgerCare or Family Planning Waiver. Eligibility for these programs can begin no earlier than the first of the month in which you apply.

- Your rights and responsibilities are provided in the *Wisconsin Medicaid Program – Eligibility and Benefits* brochure (PHC 10025). If you do not have a brochure, you may obtain one at your local county/tribal social or human services department or by calling Medicaid Recipient Services at 1-800-362-3002. If you have any questions about your rights and responsibilities contact your local county/tribal social or human services department or Medicaid Recipient Services at 1-800-362-3002.

- If you are found eligible for Medicaid, BadgerCare, or the Family Planning Waiver you will need to complete a review every 12 months to determine eligibility. Changes in your income or household composition need to be reported to your county/tribal social or human services department within 10 days of occurrence. For the Family Planning Waiver program, only changes in household composition and residency need to be reported within 10 days.

SECTION I – Client Information

Do you need help paying for health care for any of the previous three months?
Check "Yes" if you need help paying for health care received during any of the previous three months. Check "No" if you do not need help paying for health care received during the previous three months. If you have checked "Yes", additional information will be necessary to process your application. Your local county/tribal social or human services department will be contacting you. **Remember:** If applying for BadgerCare or the Family Planning Waiver you cannot have your eligibility backdated for the previous three months.

Is there anyone blind, disabled or incapacitated in your household?
Check "Yes" if anyone in your household is blind, incapacitated or has a disability. Check "No" if no one in your household is blind, incapacitated or has a disability. If you check "Yes" more information is necessary and you will need to complete the Elderly, Blind and Disabled Medicaid Application. Your local county/tribal social or human services department will contact you.

Check the language that you want notices printed in.
Check "English" if you would like your notices printed in English. Check "Spanish" if you would like your notices printed in Spanish. If you need assistance with translating any notice you receive into another language other than English or Spanish, contact your local county/tribal social or human services department.

Language spoken in the home.
Enter the language spoken most often in your home.

Case Number
Do not fill in shaded area.

Date Received
Do not fill in shaded area.

Name of Person Applying for Aid
Enter your last name, first name and middle initial of the person applying for Medicaid, BadgerCare, or the Family Planning Waiver benefits.

Telephone Number
Enter your 10-digit telephone number (include area code, for example (608) 292-4021).

We assume your children attend school full time. If not indicate here.
List the first and last names of your children, who are under 18 years of age, who do not attend school full time.

Address
Enter your address, street, city, state and zip code.

Mailing Address
Enter the mailing address where you would like information sent regarding your Medicaid/BadgerCare eligibility. This may be your current address or the current address of your authorized representative. You may use the mailing address as an alternate address of where you would like to receive confidential information regarding the Family Planning Waiver.

SECTION II – General Information

Eligibility for Medicaid/BadgerCare will be based on family members living in your household. Complete this section of the application for all family members living in your household.

Name
Enter the last name, first name and middle initial of all family members living in your household. This may include yourself, your spouse, father, mother, children or stepchildren, etc. If you are under 18 years of age applying only for the Family Planning Waiver for yourself and do not have a spouse or child, only enter information about yourself.

Applying for Medicaid?
For each member of your household check "Yes" if that member is requesting Medicaid/BadgerCare. Check "No" for each member of your household who is not requesting Medicaid/BadgerCare.

Applying for the Family Planning Waiver?
The Family Planning Waiver provides limited Medicaid benefits in the form of family planning services for women between the ages of 15 and 44. Women applying for the Family Planning Waiver do not need to apply for Medicaid/BadgerCare, but it would be in your best interest to apply because Medicaid provides access to full benefits.

Check "Yes" if any woman in your household, between the ages of 15 and 44, is applying for the Family Planning Waiver. Check "No" for any woman in your household, between the ages of 15 and 44, who is not applying for the Family Planning Waiver.

If you do not check "Yes" or "No" the application will be processed assuming "No" for those women between the ages of 15 and 44.

Social Security Number
Enter a Social Security Number (SSN) for all members of your household who are applying for Medicaid, BadgerCare or the Family Planing Waiver. If someone in your household is not applying for Medicaid, BadgerCare or the Family Planning Waiver you do not need to provide SSN information for that person.

Providing or applying for an SSN is voluntary; however any person who wants Wisconsin Medicaid but does not want to provide their SSN or apply for one will not be eligible for benefits, pursuant to Wisconsin Statutes section 49.82(2).

If you are applying only for emergency services because of your immigration status; you do not need to provide SSN information.

SSN information will be used for administration of the Medicaid program. Your SSN permits a computer check of your information with government agencies such as the Internal Revenue Service (IRS), Social Security Administration (SSA) and the Department of Workforce Development. In addition, the Department will match your name and SSN with information provided by health insurance carriers to determine if you have other health insurance.

Your SSN will not be shared with the Immigration and Naturalization Service (INS).

Date of Birth
Enter the birth date of all members of your household. When entering the birth date, use the number for the month, day and year. (Example: If your birth date is February 23, 1970, enter 02/23/70.)

Gender
Circle "M" for each male member of your household. Circle "F" for each female member of your household.

Marital Status
Enter the code in the space provided that best describes each household member's marital status.

- A = Annulled
- D = Divorced
- LS = Legally Separated
- M = Married
- S = Separated
- N = Never Married
- W = Widowed

Are you a U.S. Citizen?
Check "Yes" for each member of your household that is a U.S. citizen. Check "No" for each member of your household that is not a U.S. citizen. If you checked "No" for any household member applying for Medicaid, BadgerCare or the Family Planning Waiver, submit a copy of both sides of the immigration documentation with this application. Information may be submitted to the INS for verification for those applying for these programs.

If someone in your household is not applying for Medicaid, BadgerCare or the Family Planning Waiver you do not need to provide proof of immigration status for that person.

What is your race or ethnic background? (Optional)
Enter the code or codes that best describe the race or ethnic background of each member of your household. This information is voluntary and will not be used to determine eligibility.

- A = Asian
- B = Black
- H = Hispanic origin
- I = American Indian/Eskimo
- P = Native Hawaiian or Pacific Islander
- S = Southeast Asian
- W = White

Relationship to Applicant
Enter the relationship to the applicant of each person listed.

SECTION III – Absent Parent Information (Use a separate sheet of paper if additional space is needed.)

A Medicaid/BadgerCare eligibility requirement is cooperation with identifying parents who are absent from the home. Complete this section as accurately as you can for each parent absent from the home. If there is a reason you do not want to provide information for an absent parent, leave this section blank.

If you are a woman, between the ages of 15 and 18 and applying only for the Family Planning Waiver for yourself, do not complete Section III.

If this section is left blank, you will be contacted by your local/tribal social or human service department for additional information, unless you are a woman between the ages of 15 and 18 applying for the Family Planning Waiver.

Do any children have a natural or adoptive mother or father who is not living at home?
Check "Yes" if any of the children living in your household have either a natural or adoptive parent who is not living in the home. If you checked "Yes", complete all of Section III.

Check "No" if the children living in the home have both natural or adoptive parents living in the home. If you checked "No", skip to Section IV.

Name
Enter the last name, first name and middle initial of any parent who is absent from the home.

Social Security Number
Enter the Social Security Number (SSN) of the absent parent, if you know it. If this field is left blank, you may be contacted by your local/tribal social or human service department for additional information.

Date of Birth
Enter the birth date of the absent parent, if it is known. When entering the birth date, use the number for the month, day and year. (Example: If the birth date is February 23, 1970, enter 02/23/70 in the space provided.)

Name(s) of Child(ren)
Enter the last name, first name and middle initial of the child(ren) of this absent parent.

Relationship to Child
Check "Mother" or "Father" to indicate the absent parent's relationship to the children listed.

Reason for Parent's Absence
List the reason why the parent does not live in the household. (For example, divorced, separated, not married, unable to locate.)

Date Parent Left the Household
Enter the date that the absent parent left the household, if known. When entering the date, use the number of the month, day and year. (Example: If the date the parent left the household is March 3, 1999, enter 03/03/99 in the space provided.)

Date of Last Contact with Parent
Enter the date of last contact with the absent parent.

Court Order of Divorce or Paternity
If there is a court order of divorce or paternity, enter the case number, county, and state for the order that was issued.

SECTION IV – Employment (Use a separate sheet of paper if additional space is needed.)

Medicaid, BadgerCare and the Family Planning Wavier eligibility will be based on your total family income, except if you are a woman between the ages 15 and 18, applying for only the Family Planning Waiver.

Enter the expected gross monthly earnings for the current month and next month for each member of your household. If you are a woman, between the ages of 15 and 18, applying for only the Family Planning Waiver your parents' and sibling income is not counted.

Are you or any household member working?
Check "Yes" if any member of your household is working and complete the rest of the Section IV. Check "No" if no one in your household is working, and skip to Section VI.

Is anyone listed in Section IV a migrant worker?
Check "Yes" if any member of your household is a migrant worker and complete the rest of Section IV. Check "No" if no one in your household is a migrant worker.

Name Working Person
Enter the last and first name of each member of your household that is employed.

Employer's Name, Address and Telephone Number
Enter the employer's name, address and telephone number for each member of your household who is employed.

Date Employment Began
Enter the beginning date of employment for each member of your household who is employed. When entering the date, use the number of the month, day and year. (Example: If the date that employment began is May 2, 2000, enter 05/02/00 in the space provided.)

Gross Monthly Earnings Expected this Month
Enter the expected monthly gross earnings (before taxes and deductions) for this month for each member in your household who is employed.

Gross Monthly Earnings Expected Next Month
Enter the expected monthly gross earnings (before taxes and deductions) for next month for each member in your household who is employed.

SECTION V – Self-Employment (Add a second sheet of paper if more than one person is self-employed.)

Are you or any household member self-employed?
Check "Yes" if you or any member of your household is self-employed. If you checked "Yes" complete the rest of Section V. List amounts you reported to the IRS on your tax forms. If you did not file taxes last year, leave the net annual income and depreciation boxes blank. Your county/tribal agency will contact you for more information.

If no one in your household is self-employed, check "No" and continue on to Section VI.

Self-Employed Person
Enter the last name, first name and middle initial of each person in the household who is self-employed.

Business Name and Address
Enter the name and address of the business for each person in the household who is self-employed.

Type of Business
Enter the type of business for each person in the household who is self-employed.

Net Annual Income
Enter the net annual income for each person in the household who is self-employed. List the amounts reported to the IRS on your tax forms. If you did not file taxes last year, leave this box blank. Your county/tribal social or human services department will contact you for more information.

Depreciation Amount Claimed
List the amounts reported to the IRS on your tax forms. If you did not file taxes last year, leave this box blank. Your county/tribal social or human services department will contact you for more information.

Income you Expect to Earn this Year
Enter the amount of gross annual income (before taxes and deductions) for each person in the household who is self-employed.

SECTION VI – Unearned Income

Other Type of Income/YES/NO
Check "Yes" if anyone in your household receives unearned income. Check "No" if those in your household do not receive unearned income. If you answer "Yes" complete Section VI for each income type.

Name
Enter the name of the person for the income types that were checked "Yes".

Gross Monthly Amount
Enter the gross monthly amount received for each income type for the ones checked "Yes".

SECTION VII – Insurance (Use a separate sheet of paper if additional space is needed.)

Does any person have medical/health insurance now, or in the previous three months?
Check "Yes" if any person in the household has medical/health insurance now, or had medical/health insurance in the previous three months. Check "No" if no one in the household has medical/health insurance now or has had medical/health insurance in the previous three months.

If you checked "Yes" answer the questions to the right of the YES/NO box.

Name/Address of Insurance Company
Enter the name and address of the insurance company.

Policyholder Name
Enter the first and last name of the policyholder.

Policy Number
Enter the policy number.

Date Began
Enter the date (mm/dd/yy) the policy began. (For example, if the date is February 2, 2001, enter 02/02/01 in the space provided.)

Date End
Enter the date (mm/dd/yy) the policy ended.

Who is covered under the policy?
Enter the first and last name of those persons covered under the policy.

SECTION VIII – Child Care (Use a separate sheet if additional space is needed.)

Does anyone in the household pay for child care or adult care so they can work, look for work, go to school or receive training?
Check "Yes" if someone in your household pays for child care or adult care so they can work, look for work, go to school or receive training. Check "No" if no one in your household pays for child care or adult care.

If you checked "Yes" answer the questions to the right of the YES/NO box.

Who pays for the care?
Enter the name of the person in the household who pays for child care or adult care.

Who do you pay?
Enter the name of the person who receives payment for child care or adult care.

Does s/he live in your household?
Check "Yes" if the person you pay for child care or adult care lives in your household. Check "No" if the person you pay for child care or adult care does not live in your household.

Who is the care for?
Enter the name of the person for whom the child or adult care payment is made.

Monthly Amount
Enter the monthly amount that is paid for child care or adult care.

SECTION IX – Child Support

Does anyone pay child support?
Check "Yes" if someone in your household pays child support. Check "No" if no one in your household pays child support.

If you checked "Yes" answer the questions to the right of the YES/NO box.

Who pays the child support?
Enter the name of the person in your household who pays child support.

Who receives the child support payments?
Enter the name of the person who receives the child support payment. (This should be the name of the absent parent.)

Monthly Amount
Enter the monthly amount that is paid or received for child support.

SECTION X - Pregnancy

Are any members of your household pregnant?
Check "Yes" if a woman in your household is pregnant. Check "No" if there are no pregnant women in your household.

If you checked "Yes" answer the questions to the right of the YES/NO box.

Name of Pregnant Woman
Enter the first and last name of the pregnant woman in your household.

Due Date
Enter the due date of the pregnant woman in your household. (For example, if the due date is April 3, 2003 you would enter 04/03/03 in the space provided.) You will need to provide verification from a medical professional of your pregnancy and the due date to your county/tribal social or human services department.

Multiple births expected?
Enter "Yes" if multiple births are expected. Enter "No" if multiple births are not expected.

Number of Babies Expected?
Enter the number of babies that is expected.

SECTION XI – Rights and Responsibilities

Your signature on the application means that you understand and acknowledge that the county/tribal social or human services department, W-2 agency and the state Department of Health and Family Services is authorized to request any information that is appropriate and necessary for the proper administration of the Medicaid program authorized under Wisconsin law.

Any person, including any financial institution, credit reporting agency, employer, or educational institution, is authorized to release this information, according to Wisconsin Statute s. 49.22(2m)(a): "The department may request from any person in this state information it determines appropriate and necessary for the administration of this section, ss.49.141 to 49.161, 49.19, 49.46, 49.468 and 49.47 and programs carrying out the purposes of 7 USC 2011 to 2029. Unless access to the information is prohibited or restricted by law, or unless the person has good cause, as determined by the department in accordance with federal law and regulations, for refusing to cooperate, the person shall make a good faith effort to provide this information within 7 days after receiving a request under this paragraph. Except as provided in subs. (2p) and (2r) and subject to sub.(12), the department or the county child support agency under s.59.53(5) may disclose information obtained under this paragraph only in the administration of this section, ss.49.141 to 49.161, 49.19, 49.46 and 49.47 and programs carrying out the purposes of 7 USC 2011 to 2029. Employees of the department or a county child support agency under s.59.53(5) are subject to s.49.83."

You have the right to appeal any action taken concerning your Medicaid, BadgerCare, or Family Planning Waiver application or on going benefits that you do not agree with by requesting a Fair Hearing. You may request a Fair Hearing by writing to:

Wisconsin Department of Administration
Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875

You may also contact your local county/tribal social or human services department and ask for a Fair Hearing verbally or in writing.

The Department of Health and Family Services (DHFS) is an equal opportunity employer and service provider. For civil rights questions, call (608) 266-3465 (voice) or (608) 266-2555 (TTY).

To file a complaint of discrimination by contacting either the:

- Wisconsin Department of Health and Family Services (DHFS)
  Affirmative Action and Civil Rights Compliance Office
  1 W. Wilson, Room 555
  Madison, WI 53707-7850
  Telephone: (608) 266-3972 (Voice); (608) 266-5555 (TTY)
  Fax: (608) 267-2147

- U.S. Department of Health and Human Services
  Office for Civil Rights – Region V
  233 N. Michigan Avenue
  Suite 240
  Chicago, IL 60601
  Telephone: (312) 886-5077 (voice) or (312) 353-5693 (TTY)

CHECKLIST

☐ Is the application complete?

☐ If you are not a U.S. citizen, did you include a copy of both sides of your immigration status documents?

☐ If you are pregnant, did you include a signed and dated note from a doctor or other health care professional saying that you are pregnant and stating the due date?

☐ Did you read the Rights and Responsibilities Section?

☐ Did you sign and date the application form?

☐ Did you include the Authorized Representative Form if you are acting on behalf of an applicant?

Send the completed application to your local county/tribal social or human services department, W-2 agency, or Medicaid outstation site. Addresses for county/tribal agencies can be found at:
http://www.dhfs.state.wi.us/Medicaid1/contacts/recipient-contacts.htm or by contacting Medicaid Recipient Services at 1-800-362-3002.

OTHER PROGRAM INFORMATION

If you are interested in services for veterans, call 1-800-947-8347 (WIS-VETS), or contact your county Veteran Service Officer.

Appendix 5
Wisconsin Medicaid/BadgerCare Family Application (for photocopying)

(A copy of the Wisconsin Medicaid/BadgerCare Family Application is located on the following page.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 10100 (Formerly DES 12277) (01/03)

STATE OF WISCONSIN
WI Statutes s.49.47

WISCONSIN MEDICAID/BADGERCARE FAMILY APPLICATION

Before completing this form, read the attached instructions. Use black or blue ink only.

SECTION I – CLIENT INFORMATION

Do you need help paying for health care for any of the previous three months? ☐ Yes ☐ No	Is in your householdanyone blind, disabled or incapacitated? ☐ Yes ☐ No	Check the language in which you want the notices printed. ☐ English ☐ Spanish	Language spoken in the home.	Case Number	Date Received

Name of Person Applying for Aid (Last, First, MI)	Telephone Number (include area code)	We assume your children attend school full time. List names of minor children not attending school full time.

Address (Street, City, State, Zip Code)	Mailing Address (only if different from residence) (Street, City, State, Zip Code)

SECTION II – GENERAL INFORMATION (Refer to instructions to complete this section.)

Names of all family members living in your household. (Example: Yourself, your spouse, father, mother, children, stepchildren, etc.) Please add second sheet of paper if more room is needed.	Applying for Medicaid or BadgerCare?	Applying for Family Planning Waiver?	Social Security Number (Applicants Only)	Date of Birth (MM/DD/YY)	Gender	Marital Status Code	U.S. Citizen (Applicants Only)	Race or Ethnic Code (Optional)	Relationship to Applicant
Name (Last, First, MI)	☐ Yes ☐ No	☐ Yes ☐ No			M F		☐ Yes ☐ No		
	☐ Yes ☐ No	☐ Yes ☐ No			M F		☐ Yes ☐ No		
	☐ Yes ☐ No	☐ Yes ☐ No			M F		☐ Yes ☐ No		
	☐ Yes ☐ No	☐ Yes ☐ No			M F		☐ Yes ☐ No		
	☐ Yes ☐ No	☐ Yes ☐ No			M F		☐ Yes ☐ No		

SECTION III – ABSENT PARENT INFORMATION (Refer to instructions to complete this section.)

Do any children have a natural or adoptive mother or father who is not living at hom ☐ Yes ☐ No (Add a second sheet if more room is needed.)

Name of Parent (Last, First, MI)	Social Security Number	Date of Birth	Name(s) of Child(ren)	Relationship to Child
				☐ Mother ☐ Father
				☐ Mother ☐ Father

Reason for Parent's Absence	Date Parent Left Household	Date Last Contact With Parent	Court Order of Divorce / Paternity Case Number	County	State

SECTION IV – EMPLOYMENT

Are you or any household members working? ☐ Yes ☐ No (If you answered "Yes" complete below.)

Is anyone listed below a migrant worker? ☐ Yes ☐ No

Name Working Person	Employer (Name, Address and Telephone)	Date Employment Began	Gross Monthly Earnings Expected This Month (Before Taxes and Deductions)	Gross Monthly Earnings Expected Next Month (Before Taxes and Deductions)

SECTION V – SELF-EMPLOYMENT

Are you or any household members self-employed? ☐ Yes ☐ No

Name (Last, First, MI)	Business (Name and Address)	Type of Business	Net Annual Income	Depreciation Amount Claimed	Income you Expect to Earn this Year

SECTION VI - UNEARNED INCOME (Refer to instructions to complete this section.)

Does anyone in your household receive unearned income? ☐ Yes ☐ No If you answered "Yes" complete section below for each income type. (Add a second sheet of paper if more room is needed.)

Type of Income	Yes/ No	Name	Gross Monthly Amount	Type of Income	Yes/No	Name	Gross Monthly Amount
Social Security / Supplemental Security Income (SSI)	☐☐		$	Disability / Sick Pay	☐☐		
Maintenance / Child Support	☐☐		$	Interest / Dividends	☐☐		$
Workers / Unemployment Compensation	☐☐		$	Veterans Benefits	☐☐		$
Other income (describe)	☐☐		$	Other income (describe)	☐☐		$

SECTION VII – Insurance

Does any person have medical / health insurance coverage now, or in the previous three months?	☐ Yes ☐ No	Name / Address of Insurance Co	Policyholder Name	Policy Number	Date Began	Date Ended	Who is covered under the policy?

SECTION VIII – Child Care (Add a second sheet of paper if more room is needed.)

Does anyone pay for child or adult care so they can work, look for work, go to school or receive training?	☐ Yes ☐ No	Who pays for the care?	Who do you pay?	Does s/he live in your household? ☐ Yes ☐ No	Who is the care for?	Monthly Amount $

SECTION IX - Child Support (Add a second sheet of paper if more room is needed.)

Does anyone pay child support?	☐ Yes ☐ No	Who pays the child support?	Who receives the child support payments?	Monthly Amount $

SECTION X – Pregnancy (Add a second sheet of paper if more room is needed.)

Is any member of your household pregnant?	☐ Yes ☐ No	Name of pregnant woman?	Due Date	Are multiple births expected? ☐ Yes ☐ No	Number of babies expected?

SECTION XI – RIGHTS AND RESPONSIBILITIES

Please read the Rights and Responsibilities section on the instructions before signing.

I understand the questions and statements on this application form. I understand the penalties for giving false information or breaking the rules. I certify, under penalty of false swearing, that all my answers are correct and complete to the best of my knowledge, including information provided about the citizenship status of each household member applying for benefits. I understand and agree to provide documents to prove what I have said. I understand that the agency may contact other persons or organizations to obtain the necessary proof of my eligibility and level of benefits.

SIGNATURE - Applicant or Authorized Representative	Date Signed

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Appendix 6
Medicaid Authorization of Representative (for photocopying)

(A copy of the Medicaid Authorization of Representative is located on the following page.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 10126 (01/03)

STATE OF WISCONSIN
WI Admin. Code HFS 102.01

MEDICAID AUTHORIZATION OF REPRESENTATIVE

This form must be completed by the person who completed the Medicaid application on behalf of an applicant. Documentation must be provided the applicant's local county/tribal social or human services department.

Did you complete a Medicaid/BadgerCare application on behalf of another person and are you that person's court appointed guardian, conservator or have durable power of attorney for finances for that person? ☐ Yes ☐ No

If you answered "Yes", stop here. You must submit, to the local county/tribal social or human services department, the legal documentation authorizing you to be that person's appointed guardian or durable power of attorney for finances.

Are you an authorized representative completing the Medicaid/BadgerCare application for another person ☐ Yes ☐ No
If you are an Authorized Representative, then you and the applicant must complete the information below and you must sign the Rights and Responsibilities Section of the Medicaid/BadgerCare application. Also, both you and the applicant must sign this form in order for you to be an authorized representative.

Name - Authorized Representative (Last, First, MI)	Telephone Number ( )
Address (Street, City, State, Zip Code)	E-mail Address (Optional)

I authorize _____(name of representative) to represent me in my application for Medicaid/BadgerCare to be filed with the county/tribal human or social services department administering the program and in the reviews of my eligibility. I also authorize my representative to provide information and documents which may be necessary to establish my eligibility for Medicaid/BadgerCare. I will provide information to my representative that will be true and correct to the best of my knowledge. My representative and I understand that penalties for providing fraudulent information could be a fine of up to $25,000, imprisoned up to seven years and six months, or both and suspended from Wisconsin Medicaid. (NOTE: Someone other than your representative must witness your signature. Two witness signatures are required if you sign with an "X".)

SIGNATURE – Applicant	Date Signed
SIGNATURE – Witness	Date Signed
SIGNATURE - Witness	Date Signed

As an authorized representative I understand that I am representing the above named applicant for Medicaid/BadgerCare eligibility and that information provided is true and correct to the best of my knowledge.

SIGNATURE – Authorized Representative	Date Signed

Glossary of Common Terms

CMS

Centers for Medicare and Medicaid Services. An agency housed within the U.S. Department of Health and Human Services (DHHS), CMS administers Medicare, Medicaid, related quality assurance programs, and other programs. Formerly known as the Health Care Financing Administration (HCFA).

DHCF

Division of Health Care Financing. The DHCF administers Wisconsin Medicaid for the Department of Health and Family Services (DHFS) under statutory provisions, administrative rules, and the state's Medicaid plan. The state's Medicaid plan is a comprehensive description of the state's Medicaid program that provides Centers for Medicare and Medicaid Services (CMS), formerly HCFA, and the U.S. Department of Health and Human Services (DHHS) assurances that the program is administered in conformity with federal law and CMS policy.

DHFS

Department of Health and Family Services. The DHFS administers Wisconsin Medicaid. Its primary mission is to foster healthy, self-reliant individuals and families by promoting independence and community responsibility; strengthening families; encouraging healthy behaviors; protecting vulnerable children, adults, and families; preventing individual and social problems; and providing services of value to taxpayers.

DHHS

Department of Health and Human Services. The United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

The DHHS includes more than 300 programs, covering a wide spectrum of activities, including overseeing Medicare and Medicaid; medical and social science research; preventing outbreak of infectious disease; assuring food and drug safety; and providing financial assistance for low-income families.

EVS

Eligibility Verification System. Wisconsin Medicaid encourages all providers to verify eligibility before rendering services, both to determine eligibility for the current date and to discover any limitations to a recipient's coverage. Providers may access recipient eligibility information through the following methods:

- Automated Voice Response (AVR) system.
- Magnetic stripe card readers.
- Personal computer software.
- Provider Services (telephone correspondents).
- Direct Information Access Line with Updates for Providers (Dial-Up).

Fee-for-service

The traditional health care payment system under which physicians and other providers receive a payment for each unit of service provided rather than a capitation payment for each recipient.

Fiscal agent

The Medicaid fiscal agent (EDS) is under contract with the Department of Health and Family Services (DHFS) to certify providers, process and pay claims, answer provider and recipient questions, issue identification cards to recipients, publish information for providers and recipients, and maintain the Wisconsin Medicaid Web site.

Presumptive Eligibility for Pregnant Women

Presumptive eligibility for pregnant women is a Medicaid eligibility category that allows an uninsured or underinsured (i.e., insured without prenatal coverage) pregnant woman to receive immediate pregnancy-related outpatient services while her application for Wisconsin Medicaid is being processed.

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